Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005729	A. BUILDING: _____ B. WING _____	C 06/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF INDIANAPOLIS	7365 E 16TH ST INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00129099. Complaint IN00129099 unsubstantiated due to lack of evidence. Survey Date: June 13 2013 Facility number: 005729 Provider number: 005729 AIM number: NA Survey team: Chuck Stevenson RN Census bed type: Residential: 61 Total: 61 Census payor type: Medicaid: 55 Other: 6 Total: 61 Sample: 3 Crownpointe of Indianapolis was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00129099. Quality Review 06/14/13 by Lisa McColly	R 000		

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TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE